LOS ANGELES COUNTY COMMISSION ON HIV

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While not required of meeting participants, signing-in constitutes public notice of attendance. Presence at meetings is recorded solely based on sign-in sheets, and not signing-in constitutes absence for Commission members. Only members of the Commission on HIV are accorded voting privileges, thus Commissioners who have not signed in cannot vote. Sign-in sheets are available upon request.

COMMISSION ON HIV
MEETING MINUTES
March 13, 2014

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS PRESENT *(cont.)*	COMMISSION MEMBERS PRESENT *(cont.)*	DHSP STAFF
Michael Johnson, Esq., *Co-Chair*/ Kevin Donnelly	Ayanna Kiburi, MPH (by phone)	Monique Tula	Kyle Baker
	AJ King, MPH	Terrell Winder	Sonali Kulkarni, MD
Ricky Rosales, *Co-Chair*	Lee Kochems, MA/James Chud, MS	Fariba Younai, DDS	Carlos Vega-Matos, MPA
Alvaro Ballesteros, MBA	Mitchell Kushner, MPH, MD	Richard Zaldivar	Juhua Wu, MA
Joseph Cadden, MD	Brad Land		
Raquel Cataldo	Rob Lester, MPP		
Fredy Ceja, MPA/Jose Munoz	Ted Liso/Douglas Lantis, MBA	**COMMISSION MEMBERS ABSENT**	**COMMISSION STAFF/CONSULTANTS**
Michelle Enfield	Abad Lopez		
Lilia Espinoza, PhD	Marc McMillin	Dahlia Ferlito, MPH *(pending)*	Dawn McClendon
Aaron Fox, MPM	Mario Pérez, MPH	Suzette Flynn	Jane Nachazel
David Giugni, LCSW	Gregory Rios	Lynnea Garbutt	James Stewart
Terry Goddard, MA	Juan Rivera	Sharon Holloway/Ismael Morales	Craig Vincent-Jones, MHA
Grissel Granados, MSW/ Maria Roman	Jill Rotenberg	Patsy Lawson/Miguel Palacios	Nicole Werner
	Sabel Samone-Loreca/Susan Forrest	Victoria Ortega	
Joseph Green/Erik Sanjurjo, MPH	Shoshanna Scholar	Angélica Palmeros, MSW	
Kimler Gutierrez *(pending)*	Terry Smith, MPA		
David Kelly, MBA, JD	LaShonda Spencer, MD		

PUBLIC			
Robert Aguayo	Darren Aiken	Herman Avilez	Heidi Booth
Rob Brooks	Geneviéve Clavreul	Joaquin Espinoza	Lawrence Fernandez
Shawn Griffin	Tina Henderson	Faith Idemundia	Uyen Kao
Roxanne Lewis	Rishi Manchanda, MD, MPH	Richard Martin (by phone)	Miguel Martinez
Kiestra McCurtis	Arlene Norris	Melissa Nuestro	Ron Osorio
William Quitaro	Daniel Rivas	Tania Rodriguez	Martha Ron
Natalie Sanchez	Hilde Sandoval	Emmanuel Tapia	Brigitte Tweddell
Albert Washington	Sharon White	Brende Wiewela	Jason Wise
Marcus Woods			

1. **CALL TO ORDER**: Mr. Johnson opened the meeting at 9:30 am.

A. Roll Call (**Present)**: Ballesteros, Cadden, Cataldo, Enfield, Espinoza, Fox, Giugni, Goddard, Granados/Roman, Green/Sanjurjo, Gutierrez, Johnson/Donnelly, Kelly, Kiburi, King, Kochems/Chud, Land, Lester, Liso, Lopez, McMillin, Munoz, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Smith, Spencer, Tula, Winder, Younai, Zaldivar

2. **APPROVAL OF AGENDA**:
MOTION 1: Adjust, as necessary, and approve the Agenda Order ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:
MOTION 2: Approve minutes from the Commission on HIV meeting(s), revised as appropriate, as presented ***(Withdrawn)***.

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
- Ms. Idemundia, UCLA Center for Behavioral and Addiction Medicine, said a new study, Masculine, will focus on HIV+ and HIV- Black and Latino MSM. It will be based at the LA Gay and Lesbian Center and the UCLA Vine Street Clinic. A new research associate position has also opened. Contact her for additional information on the program or the position.
- Ms. White noted 3/10/2014 is National Women's and Girls' HIV/AIDS Awareness Day. She called attention to County condom distribution figures: 2011, 60,000 male, 600 female; 2012, 496,000 male, 2,300 female; 2013, 191,000 male, 5,200 female which expended the remaining supply. The LA Women's Collaborative previously advocated at the Commission for gender equity. Female condoms/dental dams empower women. The County needs to step up.
- Ms. Rodriguez, Pals for Health, has worked in the field for over 16 years and has noticed a decrease in women's services.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
- Regarding National Women's and Girls' HIV/AIDS Awareness Day, Ms. Roman urged addressing women's and trans women's services as a whole. Many services now target one population or the other. APAIT held an event last year for women and trans women to discuss issues that pertain to both. It is important to continue the dialogue.
- Ms. Enfield, Program Coordinator, Red Circle Project, APLA, also supported a continued dialogue and called attention to addressing inequalities such as the emphasis on male condoms in the "One Condom" campaign on Facebook.
- National Native HIV/AIDS Awareness Day is the first day of spring, 3/20/2014. Red Circle Project is hosting two events: 3/19/2014, United American Indian Involvement, 6th and Bixel; and 3/21/2014, Chimbole Cultural Center, Palmdale.
- This year the Pride event will be TLGBT Pride with a special emphasis on the transgender community. There will be a dedicated trans space as well as social marketing on trans awareness and gender identity.
- Dr. Spencer said, as a women's provider, she shares in the concern for improved women's and girls' support.
- She presented a letter from Geoff Milam, LCSW, who has served eight years as a mental health clinician, supervisor and program coordinator at two DHSP-funded organizations. He called for continued DHSP support for integrated, holistic, HIV-focused individual, group and family psychotherapy. The Affordable Care Act (ACA) offers new mental health options, but they are time-limited, have a higher level of "medical necessity," may not be HIV-sensitive or lack space for new clients.
- Mr. Rivera said Commission Committees often talk about mental health in terms of consumers qualifying for various systems or combinations of systems of care, but it seems like passing a hot potato. A consumer nay be too sick for one system, but not sick enough for another. The Commission needs to address mental health holistically.
- Mr. Land said mental health services are a Planning, Priorities and Allocations (PP&A) Committee issue. Considerations include Ryan White as a payer of last resort and the specialty nature of HIV services especially psychosocial services. Historically, psychosocial services have been a gateway into the system to help communities come together, feel safer, reduce stigma, increase education and increase adherence to medical care.
- The Department of Mental Health (DMH) said a few years ago it was unable to address PLWH. One of PP&A's Priorities-and-Allocations Directives this year will be to request DMH contribute to providing services. It is also important to emphasize to DHSP that needed services not available in other systems do qualify as Ryan White payer of last resort services.
- Ms. Rotenberg is part of a planning group to support the San Diego host committee for the National Minority AIDS Council United States Conference on AIDS (USCA), 10/2-5/2014. The 10/2/2014 lunch plenary session will be live streamed at the California Endowment. AIDS United is assisting with a scholarship fund for a few community members to attend and relay information on their return. She encouraged local organizations to submit abstracts in time for the 4/4/2014 deadline. The planning group also includes Ms. Enfield, Mr. McMillin, Ms. Tula and several community members. It meets monthly.
- Mr. McMillin announced Life Group LA will host a POZ Life Weekend in Long Beach next month. The event is affirming for both HIV infected and affected. Flyers were on the resource table and information is available at www.LifeGroupLA.org.

- Dr. Espinoza, Co-Chair, Latino Caucus, acknowledged the Caucus has not met regularly due to a variety of reasons, but the Co-Chairs will meet next week on the issues. She is also developing a survey on participation interest, preferred meeting days/times, frequency and logistics, e.g., the Commission office may not be the most convenient site. Commission members need not be Latino/a to participate. Contact Dr. Espinoza with questions or for additional information.
- ➲ Refer female condom issue to Executive Committee and request additional information from administrative agency.

6. **CONSENT CALENDER**:

A. Policy/Procedure #08.2107: Consent Calendar:
MOTION 3: Approve the Consent Calendar, with Motions 7, 8 and 9 postponed ***(Passed by Consensus)***.

7. CO-CHAIRS' REPORT:

A. Secondary Committee Assignments: Mr. Johnson noted the Secondary Committee Assignment Request Form in the packet. There are more alternates in this iteration of the Commission. Since they sit behind their full member on committees, he encouraged them to consider a secondary assignment to a committee where they could routinely vote.

8. EXECUTIVE DIRECTOR'S REPORT:

- Mr. Vincent-Jones apologized for the packet delay. There were copier problems. Staff is also experimenting with new packet formats in response to feedback that the traditional format is hard to follow and documents are difficult to locate.
- The two-packet set of materials today is another effort to streamline the process by preparing early materials in advance.
- Mr. Vincent-Jones also plans to follow-up on potential use of tablets and electronic viewing for meetings. The County is unlikely to approve the estimated $20,000 to $30,000 cost so alternate funding suggestions are welcome. Mr. Pérez has offered DHSP support for the transition. This green initiative would cost less than the annual cost of paper
- It also will address the real problem presented by equipment that is not equal to the copying requirements for increasing work. The staffing shortage is likely to continue for four or five months adding to the stress of copying materials.

A. Form 700: Statement of Economic Interest:

- Mr. Vincent-Jones said Commission members should have received the Form 700, 2013/2014 Statement of Economic Interest electronically or in the mail. A copy was in the packet and extras are available from the Commission Office.
- State law pertaining to Conflict of Interest rules requires Form 700. Fines are assessed on the individual after the deadline and can reach $1,000 per day. They cannot be charged back to the Commission.

9. **PARLIAMENTARY TRAINING**: There was no training.

10. HIV REASEARCH AND COMMUNITY COLLOQUIA SERIES: THE UPSTREAMISTS:

- Ms. Kao, Center for HIV Identification, Prevention and Treatment Services (CHIPTS), introduced Dr. Manchanda, President and Founder of HealthBegins which provides training and consulting services to health professionals and organizations in transforming their care delivery and addressing social determinants that cause ill health. He is dual board-certified as an internist and pediatrician and leads a Los Angeles program for high-utilizer homeless Veterans.
- The colloquia will be recorded with video posted on the CHIPTS website in the next few weeks. The Upstream Doctors, Dr. Manchanda's TED ebook, will also be made available for all participants. Ms. Kao urged everyone to complete the survey on the colloquium and how to best incorporate colloquia in Commission meetings, e.g., format, length and frequency.
- Dr. Machanda emphasized he is a primary care physician. He always knew that the biomedical system focused on managing disease, but also knew from his international experience that health is more than what happens in the clinic. His passion is to help people become healthier using the health care experience to understand social and environmental conditions.
- He framed the conversation in terms of value. It is clear to our patients and communities that services have implicit value, but payers are now asking questions of value and ready solutions are often near term and technological fixes. Another model that offers value, but not used as often, is collaborative, interdisciplinary, coordinated care that marries social, environmental, medical and mental health. Now is the time to define how to provide the best value.
- He was Director of Social Medicine at a South Los Angeles clinic for several years. He exemplified the collaborative approach with a patient case study. "Veronica" visited the clinic in her mid-30's. She had suffered for three years from chronic, worsening headaches despite multiple primary and Emergency Room (ER) visits including three ERs in the prior three weeks. At the first of these, she received a CAT scan, a spinal test and multiple blood tests. Tests were normal. She was prescribed Vicodin and told to come back if pain persisted or increased.

- "Veronica" followed instructions. Pain persisted. She visited two other ERs in hopes of a better result. The same process was repeated. She was not only ill, but exasperated, when she reached the community clinic. Her frail mother was increasingly required to care for her two sons and her employer was becoming less understanding.
- On review, his colleagues had individually provided good care on paper, e.g., ordering tests and prescribing follow-up care. Collectively, however, they had failed to provide the proper standard of care to address the issue.
- The community clinic medical assistant collected routine medical information, but also a seven-question survey from the American Housing Survey to screen for housing risk factors. The clinic developed those questions based on community collaboration and a Survey Monkey tool on social and environmental conditions that the clinic should address.
- "Veronica" had answered three of the seven questions in the affirmative: roaches, mold and water leaks. In 12 minutes, with all pertinent information and a patient exam, Dr. Manchanda diagnosed allergic rhinitis with associated sinus headaches and migraines. It was the first diagnosis "Veronica" had had. He prescribed medication for symptoms and referred her to a community health worker associated with the clinic to coordinate advocacy with her landlord to resolve the housing issues. After three months, "Veronica" reported 90% of symptoms had resolved and her housing was better.
- That is the better standard of care to which health care professionals should aspire. Treating people without addressing the conditions that make them sick is a losing value proposition as well as substandard care. American healthcare is past the point of diminishing returns in part because social, contextual and environmental data and the ability to act on it is missing.
- Costs are in preventable illness and health disparities from less effective interventions. Patients develop mistrust and misengagement. That leads to work force recruitment and retention issues as providers burn out addressing frustrated patients with nothing to offer except perhaps a disjointed connection to community and social services.
- The Joint Center for Political and Economic Studies, a Washington DC think tank, estimated just the national costs associated with health disparities at $400 billion per year. The three-year study period cost was $1.24 trillion.
- Clinics are impacted in competitiveness, effectiveness and productivity especially as payment reform moves toward a value-based system. Social determinant interventions have become a notable approach to address hot spots and high-utilizers, but Dr. Manchanda felt high-utilizers are a symptom of missed opportunities. "Veronica" became a high-utilizer because multiple health care providers did not ask her about where she lived. The system creates high-utilizers.
- Patients can be co-creators of their care. Many glimpses of a better standard of care were developed in the HIV world as it made sense to create case management programs and wrap-around care to meet needs, e.g., for housing and food.
- All such glimpses of a better standard of care share a focus on social determinants. Approximately 60% of premature mortality is attributable to social factors with 20% due to social environmental factors. Only 10% is attributable to the health care sector. Some say the issue is not where someone lives or works, but behavior choices are informed by the built social environment, e.g., attendees would not "choose" to sit for this colloquium if the chairs were removed.
- Dr. Manchanda believes the health care sector can optimize its work by leveraging it upstream with social determinants to impact that 10%. A United Kingdom study addressed how place impacts health. Populations with greater access to green space had lower rates of death from cardiovascular disease. Health disparities also decreased as income rose. As a physician, he can write a statin prescription for cholesterol, but lacks a way to translate the data about green space.
- A study conducted in Botswana and Swaziland interviewed 2,051 adults in a cross-sectional survey on food insufficiency and HIV risk factors. Approximately one-third of women and one-quarter of men had experienced food insufficiency. That was associated with HIV risk behavior especially among women, i.e., inconsistent condom use, sex exchange, increased intergenerational sex and lack of control over sexual relationships. Food insecurity is a marker of poverty. It is associated with risk behavior because someone who is hungry will transact what the person has – his or her body.
- The study of epigenetics has shown that our zip code at a molecular level is shaping our genetic code now and has done so for generations. Science is demonstrating that nature and nurture are integrated at a deep level.
- Dr. Manchanda compared clinical practitioners to three friends who come to a river, see a child drowning and jump in to save the child. To their dismay, they see more children and adults drowning so they remain in the river to rescue them. Over time, one friend focuses on rescuing people on the verge of drowning near the water's edge. Another builds a raft to rescue people further upriver before they reach the water's edge. The third friend swims upriver rescuing children as she goes. When asked where she is going, she shouts back, "I'm going to find out who or what is throwing people in the water."
- Today, the specialist or partialist is the friend at the water's edge, e.g., trauma surgeons, ER physicians and oncologists. The comprehensivist is the friend who builds the raft, e.g., the person coordinating a medical home. The upstreamist is the friend swimming upstream, i.e., someone in the health care system who is optimizing the system's value by ensuring patients are systematically asked about housing and other social determinants and issues are addressed within the system.
- According to a nationwide survey, approximately 80% of physicians and providers know that social determinants matter as much as health issues, but only approximately 20% were confident they could address them in their system.

- A HealthBegins practitioner survey in South Los Angeles found approximately 25% confidence in addressing social determinants, but was able to triple that percentage in 11 months. It provides three-and-one-half hour workshops on a methodology to create an upstream intervention in clinics including a project plan, draft budget and PowerPoint pitch. Practitioners are surrounded with local content experts including the community and patients to elevate and recognize the value of the expertise of a patient, a resident or community member. Follow-up coaching is provided via Skype.
- HealthBegins has also partnered with a charter high school in South Los Angeles, Alliance Health Services Academy. Three cohorts of approximately 30 students each have participated in a model of community health detailing. Each week students learn about a social determinant such as housing or food insecurity and how it links to health and health care. Students then map local resources for that social determinant. Resources include social services and provision of care, but also community organizing resources and organization and mobilization of care. Finally, they share what they have learned with physicians – both the importance of social determinants and a tool to help physicians find resources for their patients.
- Two-thirds of students agree or strongly agree that they are confident they can help clinics take care of patients with social needs. Approximately 80% of students are confident that they can help someone with a social need find services.
- That is important because many social needs can be addressed in the community before individuals access the health care system. Students have developed and are powering a Yelp-like interface that builds community capacity to address needs.
- He encouraged providers to ask themselves the same questions students are asking in their detailing work:
  - Is the clinic that you go to or that you work in providing a high value, better standard of care?
  - Do you regularly identify the health and social needs?
  - Do you have a dedicated person or team working to address social conditions as part of your staff at a patient level and a population level?
  - Are you routinely screening patients for risk factors in their social environment?
  - Do you routinely connect patients to social needs environmental resources that go beyond the level of the individual patient and help improve social environmental conditions?
  - Do you reflect this upstreamist approach in the way you fund your work?
- Many here may do these things, but the approach and funding for it must always be optimized. Health care cannot be done right without addressing social determinants. It cannot be acquired as a right without addressing them. Addressing payer sources for health care is important, but it will be insufficient without addressing them. Focusing on public health and social determinants alone cannot be effective as efforts will be overwhelmed by the system. Instead, the two must be integrated.
- Dr. Younai, Co-Chair, Standards and Best Practices (SBP) Committee, said SBP is focusing on social determinants of care. The HIV system of care is one of the best in this regard, but the ACA is changing the landscape. She asked how to best interact with the current system of health care to ensure social determinants are addressed.
- Dr. Manchanda recommended addressing five areas of activity. Not everyone needs to address each area, but they can be addressed collectively. The five areas are: the business case; community and policy engagement, e.g., encouraging voter registration; data and technology; design such as creating interventions; and work force.
- The business case offers opportunities for alignment. The Accountable Care Organization (ACO) financial structure creates risk- and benefit-sharing among stakeholders many of which are clinical providers. The HIV community can advocate for social providers to be among stakeholders at the table. There they can identify questions and normalize the understanding of value that social service and community organizing efforts offer so they can be integrated into the health side.
- Medicaid Managed Care Organizations (MCOs) may not be driving the social determinants conversation, but are positioned to move it. They have the institutional characteristics since many MCOs arose out of a social mission and many are not-for-profit. They also have many members with disproportional social needs. Finally, while they do have Fee-For-Service, the capitated financial model is still prominent so there is inherent interest in fee-for-value.
- Efforts can begin by understanding what MCOs are already doing, e.g., most focus on the community side, e.g., at farmers' markets. The HIV system of care can help inform MCOs on how to integrate that with the clinical side.
- Mr. McMillin said it sounded as though "Veronica" did not advocate for her own health care as strenuously as she might have. Dr. Manchanda noted one ER provider told her he thought she was seeking drugs. There are stereotypes particularly in a system that lacks time to listen to a patient's social context or reimburse to address issues. Medicine has emphasized the biomendical approach so well that a Louisville KY survey found the poorest respondents said bad health outcomes were related to bad behavior. Consumers should be educated to place behavior in the context of social determinants.
- Mr. Liso is on a quality management board. Social determinants were the most raised issue in the western half of the country. People want an engaged and interested physician, but the typical ACA visit is 20 minutes of clinical work with social issues pawned off to an overworked assistant who passes over information so quickly the patient leaves confused.

- He had a housing problem like "Veronica's" that resulted in two years of health problems so severe he passed out twice. He raised the issue repeatedly with his physician, but eventually sued and won. Physicians should take the lead.
- He added social determinants are especially critical for women since they often have children and meet those needs first.
- Dr, Manchanda said community involvement can provide the frame that allows providers who want to address social determinants to do so. Community members can ask physicians and administrators if their clinic is upstreamist.
- Mr. King felt we are all responsible from the individual consumer to the provider to the system, but there are barriers to overcome at each level, e.g., a consumer like "Veronica" knows social determinants by other terms, but may not be heard if she raises them. He felt Patient-Centered Medical Homes (PCMHs) would be a natural fit to better address these issues.
- Dr, Manchanda replied HealthBegins links the upstreamists it trains to current strategic priorities at their clinics with a focus on PCMHs. The most effective way to move change is through PCMH Standards 4A and 4B from an accrediting organization in Washington DC. Standards define three levels and link to increased reimbursements. Some Standards, especially 4, pertain to community linkage, e.g., updated community resources. Stakeholders can help a clinic meet those Standards.
- The most effective way to drive change is to find a pain point, help address it and use the entry point to organize.
- Mr.Zaldivar noted some organizations have addressed social determinants for years and could present on their experiences.
- Ms. Scholar said her organization runs a syringe exchange program that works with active drug users. They are less likely to have primary care, but are high utilizers of ER services. The program is trying to determine its role in PCMHs and is running a pilot to provide case management incentives combined with clinic training to improve engagement.
- Dr. Manchanda said upstreamists are a necessary part of the clinic health care work force, but one of their functions is also to identify, work with and develop community partnerships. Not all work must be in the clinic. It may be more effective to maintain outside resources. The upstreamist should do an environmental scan and determine which is best.
- He often uses a three-by-three way grid of preventions when determining how to design the first upstream intervention for a clinic. One axis is primary, secondary and tertiary. The other is patient-level, population-level and system-level. The syringe exchange intervention is tertiary, patient-level. Patients are high-utilizers with high rates of diseases associated with dirty needles. They are potentially high-cost for the clinic which is also unlikely to be organized to care for them. The syringe exchange program can show a case for coordinating care with the PCMH beneficial to both.
- A secondary tier system-level intervention might be a Kaiser Permanente farmers' market which helps all the patients. The clinic might think about a system-level education program or needle exchange information session for the clinic population. Providers like a structure such as a three-by-three grid to help categorize how an activity fits in their organization.
- Regarding a system for implementation, cost and cost effectiveness data, Dr. Manchanda said HealthBegins was 18 months old, has offered trainings the entire time and had eight staff. Trainings initially addressed reported needs, e.g., the California Primary Care Association requested a webinar on care teams, medical homes and social determinants.
- The methodology was used from the start, but three months ago the focus shifted to scale for a system-level impact. The goal is now to provide the methodology. Most current clients are academic health centers and some hospital systems that bring their own providers as well as community partners to the table.
- It is too early for cost effectiveness data, but shorter term client feedback reflects tripling of social determinant knowledge. HealthBegins is a training and capacity building organization rather than an independent prevention organization.
- The community health detailing model and the Yelp-like interface pilot are at the 16th Street Clinic. That is the continuity clinic for the UCLA Medicine and Pediatrics residency program. Workshops are provided in Seattle, WA; Texas and California including a new site opening in three weeks in Santa Rosa. They have been invited to Canada.
- Dr. Kushner stressed that community physicians are seeing some 30 patients daily with about half uncontrolled diabetics. The Long Beach Health Department has a one-month rotation of third year family practice residents. He is struck by their lack of training in social determinants. He recommended outreach to medical and nursing schools to start training earlier.
- Dr. Manchanda addressed the Association of Academic Health Centers in Washington, DC on 3/10/2014. Academic health centers and medical schools are thinking about this work. The community can advocate for that. He noted, however, that medical school is four years with three to seven more for other specialty training. The work shops can provide a short methodology engagement followed by coaching with connections to the community and a growing group of upstreamists.

11. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. OA Work/Information:

- Ms. Kiburi. Chief, HIV Care Branch, representing the Ryan White Med-Cal Waiver, HOPWA and Minority AIDS Initiative Programs introduced Mr. Martin, Chief, Insurance Assistance Section (IAS) representing the ADAP Branch.
- Ms. Kiburi reported the Ryan White Part B HIV Care Program launched a series of Best Practices teleconferences with Part B service providers on 2/27/2014. The call addressed health insurance premiums and cost-sharing assistance.

- The series opens a forum for contractors/subcontractors to address issues related to ACA implementation, reporting and policies/procedures. Calls will be the fourth Thursday of the month, 1:00 to 2:00 pm, and include a 10 to 15 minute presentation from staff in the field followed by Q/A. The contact is Marjorie Katz at www.marjorie.katz@cdph.ca.gov.
- Ms. Kiburi noted the Commission requested information on why OA did not apply for the mew CDC Funding Opportunity Announcement (FOA), PS-14-1410, Secretary's Minority AIDS Initiative Funding to Increase HIV Prevention and Care Delivery Service among Health Centers Serving High HV Prevalence Jurisdictions. She reported OA discussed the FOA with the six highest prevalence Local Health Jurisdictions (Los Angeles, Sam Francisco, Sam Diego, Orange, Alameda and Riverside). After extensive discussion with them, OA concluded it could not meet the FOA criteria.
- Mr. Martin said IAS is communicating changes to the program from healthcare reform. Three policy memorandums to OA-HIPP enrollment workers were released in February 2014. They describe OA's policy on payment of family/dental polices; how to document a client's monthly Covered California tax credit amount; and how clients can request assistance on customer service issues. Memos are available under Management Memorandums – 2014 at www.cdph.ca.gov/programs/aids/Pages/OAIAS.aspx.
- OA is working with representatives from Covered California and Blue Shield to resolve premium payment issues. OA sent premium payments for 92 OA-HIPP clients/Blue Shield members that were not processed. Clients were able to access medications through ADAP, but not Blue Shield services.
- As of 2/28/2014, OA has received confirmation that 62 members either have insurance or the payment was being applied. Work continues to ensure remaining clients have insurance coverage and to avert future issues.
- Mr. Land noted barriers in accessing the 250% Return to Work Program regarding how the share of cost process works.
- Mr. Rivera said a January letter to consumers enrolled in ADAP included language to the effect that they had 30 days to contact Ramsdell if they had outstanding ADAP issues or missing documents. Many consumers misread that to mean some of their documents were missing. He suggested not including that kind of language in future to avoid confusion.

➲ Mr. Land will email Ms. Kiburi details on the 250% Return to Work share of cost issue. She will raise the subject on the Stakeholders call later that day.

➲ Mr. Martin will review the January letter to consumers enrolled in ADAP with a view to revising language for better clarity. Ms Kiburi added the Stakeholder Advisory Committee is also now reviewing documents to improve clarity.

B. California Planning Group (CPG):

- Ms. Kiburi reported final decisions on applications were made 2/21/2014. Applicants have been informed of decisions.
- For additional information about the CPG, contact Liz Hall at 916.449.5951 or www.liz.hall@cdph.ca.gov.

12. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT:

A. Administrative Agency:

- Mr. Pérez, Director, reported DHSP has still not received the final portion of the Ryan White Year 24 grant award notification. That makes last week's Planning, Priorities and Allocations Committee contingency planning work all the more important. Early indications suggest there may not be a significant decrease this year compared to last year.
- There was a legal challenge, essentially a sole source complaint, to DHSP contracting with a set of providers in response to a Federal application for a Substance Abuse and Mental Health Services grant that would integrate HIV screening, behavioral health and substance abuse services into a high-volume primary care setting in an underserved area. DHSP identified St. John's Well Child and Family Center, South Los Angeles, to build their capacity to integrate and address some of these issues. DHSP also partnered with UCLA given its expertise in addiction medicine. The judge ruled on 3/7/2014 that the County was justified in the manner it identified and contracted with the providers.
- The result was important since DHSP continues to aggressively compete for Federal resources. Sometimes partners need to be identified in advance to strengthen an application. A 12- to 18-month RFP process would preclude applying. The ruling also impacts the Commission since it will help DHSP shift resources quickly to meet changing priorities.
- There was a separate challenge to DHSP entering into a sole source contract with a local provider, Reach LA, that provides among other things linkage to care and outreach services particularly to young Black and Latino men primarily in South Los Angeles. The judge ruled against DHSP which means DHSP must respond to the court's mandate (writ) to terminate that contract. After several initial steps, the contract must be terminated in 45 days.
- People have enquired whether DHSP will be able to avert interruption of services. It does not appear the interruption can be averted for young Black and Latino men who are HIV+ or at risk for HIV in high burden geographic areas. DHSP will be working to identify other ways to re-initiate services as soon as possible.

- The Reach LA award was made in response to another contractor not performing as expected. There was, however, a long delay in establishing the alternate services which was identified as a problem by the judge.
- Ms. Tula asked why the two judgments differed. Mr. Pérez replied the judge bifurcated the issues because the first ruling pertained to a response to a Federal grant opportunity with a clearly defined timeframe of approximately 41 days from announcement to deadline. That convinced the court that DHSP was precluded from doing a full countywide RFP to identify the partners for the application. In the other case, there was an 18-month time gap between sunset of the contract for the last provider of the services and DHSP's recommendation to the Board for Reach LA services.
- DHSP had worked on the latter contract with negotiations, budget review and so on, but the judge found it excessive.
- Mr. Zaldivar was frustrated to hear service delivery was obstructed due to petty politics. The decrease in proportion of those with undiagnosed HIV does not remove the responsibility to serve those at most need in communities of color. As Commission members, we should educate our communities about this situation and mobilize people.
- Mr. Land asked if the Commission could help to shorten the procurement process. Mr. Pérez appreciated suggestions. Every required step in the process has been itemized, e.g., providers want 60 days to respond once an RFP is released.
- Then DHSP must hold one or more bidders' conference(s). There may be multiple addenda, e.g., recent RFPs have had eight or nine addenda. Questions must be inventoried and responded to, sometimes with legal interpretation.
- Another aspect that takes significant time is that in today's resource constrained and competitive environment more and more experts in a field are also applicants or tied formally to an applying agency. That precludes them from serving on a peer review panel. DHSP now must often recruit panel members from other jurisdictions, e.g., San Francisco, Houston, Chicago or New York. That complicates facilitation and also necessitates an orientation.
- DHSP continually works to shorten the timeline, but it quickly adds up to over a year. That means the process is often incongruent with external timelines, e.g., Federal grant opportunities with timelines of 60 or even 30 days.

B. HIV/STD Services:

- DHSP has decided to recommend the Board approve an extension of prevention contracts for approximately 18 months. That would allow time to complete the solicitation processes for multiple elements of the HIV prevention response which increasingly also includes STD control. Letters to providers went out this week.
- DHSP is also finalizing its five-year report to the CDC on Los Angeles County STD control efforts for 2009 to 2013. It will be a respective summary of what was agreed to and put in place in 2008. It should provide information on levels of productivity. It probably will not clearly identify what intervention(s) has the largest effect on reducing STD burden.
- 2014 is the first year of the next five-year cycle. The CDC has allowed the County, for the first time, to take stock of the STD control response. That will offer the opportunity in 2015 to implement a set of programs, services and activities that DHSP believes will have the greatest impact on reducing STD burden.
- Mr. Pérez anticipated by October or November 2014 DHSP will be able to provide a summary of the five-year report and, more importantly, a better sense of the recommended focus for the next four years.
- DHSP is now preparing an application response to the CDC's most recent Community Approaches Responding to STDs grant. DHSP will propose continuing some of the important work being done in South Los Angeles while using the grant as a springboard to expand services countywide. The due date is 4/10/2014.
- Mr. Vega-Matos, Chief, Care Division, said 2/28/2014 marked the first full year since implementation of Ambulatory Outpatient Medical (AOM) on a Fee-For-Service (FFS) pay structure. DHSP is working with agencies to close the first year. DHSP provided a brief report to the Board. Once data is more complete, DHSP will update the Commission.
- It has also been a full year since implementation of Medical Care Coordination (MCC). DHSP hosted January meetings of all community partner and Department of Health Services clinic MCC teams. The meetings were productive and identified some areas for continuous improvement. Feedback on the service itself has been positive, but DHSP has also heard about challenges in deploying a new system-wide service. DHSP is working with providers to address concerns.
- DHSP has preliminary MCC outcome evaluation data and will work with the Commission to present data for providers with a full data set. He thanked providers who are part of the 41 HIV medical homes in the County for working with DHSP and the Commission for their partnership with DHSP in making this transition.
- Mr. Vega-Matos reported all contracts for the second phase of the oral health expansion have been implemented. Some providers are still ramping up, but preliminary data for the year can be presented in a couple of months.
- The HRSA-supported oral health TA consultant just submitted a report on efficiencies, potential efficiencies and productivity from the current provider network. The Oral Health Advisory Committee will meet in the next few months to discuss the report. It will also develop strategies on how to interact with the restoration of Denti-Cal in light of the Commission's investments over the last three years to expand oral health capacity.

- Regarding the earlier mental health discussion, DHSP has met with DMH and LA Care and is seeking a meeting with Health Net. Covered California mental health and substance abuse coverage also needs to be clarified. The AIDS Alliance is working on the issue. DHSP will be meeting with mental health providers to offer more guidance.
- Mr. Chud asked if there was information on the cost of oral health implants. Mr. Vega-Matos replied DHSP has contracts with the two main dental schools in the County at UCLA and USC. They provide general dentistry and endodontics to eligible patients. The goal is to preserve teeth and fill gaps left by other payers.

C. Research/Surveillance: Mr. Pérez said it appears the proportion of people with undiagnosed HIV infection in the County is decreasing. Historically, DHSP has estimated 20% to 21% of PLWH were undiagnosed. The revised 2013 CDC estimate, corroborated by DHSP, was 18.1%. Last week surveillance team members estimated 15.8%. That remains above the National HIV/AIDS Strategy goal, but is still hopeful.

14. STANDING COMMITTEE REPORTS:

A. Planning, Priorities and Allocations (PP&A) Committee: Commission members identified their conflicts of interest.

1. ***FY 2013 Allocation Revisions***:

- Mr. Ballesteros noted FY 2013 ended 2/28/2014 so a full year of both allocation and expenditures is available. PP&A reviewed that data and adjusted allocations to reflect over- and under-allocations.
- Multiple changes occurred during the delivery system this year, e.g., implementation of AOM FFS, MCC and ACA. PP&A expected allocation adjustments would be needed to reflect the impact of changes once data was available. Allocation adjustments are made so the Grantee can present final numbers to the Commission for its review.
- Mr. Johnson added the Commission must provide a letter of concurrence to HRSA that verifies the Grantee has expended funds consistent with the direction of the Commission. This is a kind of clean-up process in which PP&A reviews expenditures, utilization and adjusts categories based on factors it anticipated would impact how services were accessed and expenditures were rolled out during the year.
- Column U in the financials presented in the packet reflected the adjusted allocations. Mr. Ballesteros reviewed the adjustments: Medical Outpatient/Specialty (MO/S), $2,850,000 increase; Medication Assistance and Access, $1,500,000 decrease; Oral Health Care, $825,000 increase; MCC, $1,400,000 decrease; Mental Health Services, $175,000 decrease; Benefits Support, $50,000 decrease; and Transitional Case Management, $500,000 decrease.
- ➲ Mr. Vincent-Jones will verify why the formula inaccurately indicates $50,000 rather than 0 for the adjustment FY 2013 adjustment Column U ending total. Individual category figures are accurate.

MOTION 4: Approve final, year-end revisions to FY 2013 allocations, as presented ***(Passed: 27 Ayes; 0 Opposed; 2 Abstentions)***.

2. ***FY 2014 Allocation Modifications***:

- Mr. Ballesteros noted FY 2014 is for the period of 3/1/2014 to 2/28/2015. Allocations are normally based on the award, but the full grant award notification has not yet been received. PP&A developed contingency funding scenarios to address potential funding reductions, e.g., from sequestration or Federal budget issues.
- PP&A will reconvene to address the unlikely event of a funding increase, but that would pose few issues. Contingency scenarios are important for potential decreases because contracts and processes are in place. Planning needs to address how best to maintain the service delivery system in the event of a decrease in funding.
- FY 2014 contingency scenarios use the just approved FY 2013 adjusted allocation percentages as a baseline.
- Scenario 1 assumes a funding cut of up to 5%. In that event, each category will be cut by the reduction amount.
- Scenario 2 assumes a funding cut of 5% to 12.5%. In that event, the six highest funded categories will be cut, i.e.: MO/S, MCC, Oral Health Care, Substance Abuse, Mental Health. PP&A chose the highest funded categories as it felt they were best able to absorb a cut. Smaller categories could be unsustainable if cut by that amount.
- Scenario 3 assumes a cut above 12.5%. Though unlikely, PP&A will call an emergency meeting to address options.
- Mr. Johnson noted original FY 2014 allocations were done in June 2013. These modifications were developed using a weighted algorithm to reduce categories, as necessary, in a proportionate manner.
- Mr. Fox was concerned at cutting categories under-allocated in FY 2013, i.e., MO/S and Oral Health Care. He added all six highest funded categories targeted in Scenario 2 are high priorities and so the most needed. He was not convinced these contingency scenarios were the best possible. While appreciating PP&A's work, he will vote no.
- Mr. Land noted PP&A has reviewed masses of input, e.g., utilization data and consumer testimony. All service categories are needed. Those with lower priorities often are essential to retain marginalized populations in care. The Commission has cut from lowest priorities before, but PP&A has hope that the system can be maintained.

- Mr. Ballesteros noted the FY 2014 baseline is higher than the original FY 2013 baseline, e.g., the modified FY 2013 MO/S allocation being used as the FY 2014 baseline is higher than the baseline allocation at the start of FY 2013. Consequently, cuts will not be as severe while protecting smaller categories. Directives also address alternate funding for some of the categories that are targeted for scenario reductions.
- Mr. Kelly complimented Mr. Vincent-Jones on the new spreadsheets. He felt they would be very helpful in future.
- He was concerned that using algorithms in allocations diminishes community input. This is an unusual year so they can be appropriate now, but he urged re-invigorating community input in the future.
- Mr. Vincent-Jones noted an algorithm like this can be a simple mathematical process. This algorithm is broken down step by step at the end of the spreadsheet for review.
- PP&A has sought the best data available throughout this process. Even final data for FY 2013 is not yet available, but PP&A went through data from each category with DHSP staff, principally Messrs. Vega-Matos and Dave Young, Chief, Financial Division, to ensure the most current and accurate data. The value of a model like this is that new data can be plugged in as it becomes available, e.g., when agencies submit their final invoices.
- He acknowledged there are two valid approaches to contingency planning: cutting larger categories or cutting from the bottom. PP&A debated its approach over multiple meetings and chose what it felt was the best fit at this time. He added lower priority categories have smaller allocations so may need to be shut down if cut significantly.

MOTION 5: Modify the FY 2014 Ryan White Parts A/B and Minority AIDS Initiative (MAI) allocations, as necessary and recommended ***(Passed: 23 Ayes; 2 Opposed; 3 Abstentions)***.

3. ***FY 2014 Directives***:

- Mr. Land said directives pertain to areas PP&A identifies during the process that might require, e.g., clarification, additional information or perhaps offer potential savings or funding. Directives may be expectations (must do), recommendations (should do) or guidance (would be best if they could be done). PP&A prioritized three this year.
- Directive 1 (expectation) requests DHSP to develop multiple alternative strategies to address late billing/invoices from contracted providers and present them to PP&A for input by June 2014. Faster data reporting will aid PP&A by providing more complete and accurate data to use in decision-making.
- Mr. Pérez noted the end goal for the Commission to do its job expeditiously is to understand the full year's expenditures as early as possible in the planning year. This year's Priorities-and-Allocations process was delayed because DHSP was unable to provide firm numbers shortly after the end of the Ryan White program year. Late billing plays a role, but other external factors also impact timely billing. DHSP will provide a list of factors.
- Directive 2 (expectation) requests DHSP conduct a fiscal and programmatic analysis of the new AOM FFS reimbursement system especially as it pertains to cost savings/increases; fiscal impact on the continuum of HIV services; compare it to the former cost reimbursement system including costs per patient and per visit; and detail FFS strengths and weaknesses. DHSP will present the report/analysis to PP&A by September 2014 for input and, at PP&A's discretion, to the Commission thereafter.
- PP&A seeks to understand the system better. In particular, PP&A wants to understand why cost savings did not materialize as expected when patients transitioned to ACA.
- Mr. Pérez noted FFS-related costs are a departure from what was estimated a year ago. The system is still in flux. DHSP will report as comprehensively as possible to include other factors such as who ultimately pays the bills.
- Mr. Vega-Matos added it is hard to evaluate a system after one year especially when the entire health care landscape was in flux, e.g., Healthy Way LA migration, ACA implementation and changes within Medicaid. The cost may not be a function of what FFS pays versus what others pay, e.g., a consumer may have had two different payer sources in the same year. He suggested doing the analysis after FY 2014 when most patients will have migrated.
- Directive 3 (recommendation) Suggest the Commission prioritize advocacy for the Department of Mental Health (DMH) to play a more direct, expeditious and contributory role providing mental health services to patients currently in Ryan White-funded care and patients who have migrated to other care due to ACA. Advocacy should consider and employ all available tools including direct communication with DMH and the Board.
- This addresses some of the points raised today regarding support for psychosocial services.
- Mr. Pérez urged looking at the entire cross-section of County mental health providers rather than DMH alone. A community of partners and providers is needed to fully address mental health challenges in addition to DMH. There are also issues pertaining to capacity, responsiveness and the products provided.
- Mr. Vega-Matos added multiple factors impact mental health services. ACA expands mental health services at least in theory. California voter approved initiatives impact how mental health services are financed and mandate some

agency practices. HRSA is also strongly encouraging DHSP to consider Part C and D investments when determining Part A/B investments. This changing environment makes partnerships all the more important.

- Mr. Ballesteros said Federally Qualified Health Centers (FQHCs) are developing significant mental health capacity. A HRSA RFP for FQHCs will expand mental health services with up to $250,000 for two years starting 9/1/2014. He encouraged helping to advocate for County FQHCs to compete for those funds.
- He remained concerned about DMH which has the largest amount of funding for indigent mental health care.
- Mr. Land said voter propositions used PLWH community support to win, but PLWH were not included in planning.
- Mr. Stewart said DHSP can add any material it feels pertinent to Directives 1 and 2 so amendment is not needed.
- For Directive 3, he suggested adding "and other community partners" after "Department of Mental Health."

➲ DHSP will augment Directive 1 with a list of other external factors that it feels impact timely billing.
➲ DHSP will augment Directive 2 with a comprehensive report on factors it feels impact FFS reimbursement costs.
➲ Directive 3 is amended to add "and other community partners" after "Department of Mental Health."

MOTION 6: Approve recommended FY 2014 Directives to administrative partners, revised if necessary and as appropriate ***(Passed: 20 Ayes; 0 Opposed; 3 Abstentions)***.

B. Public Policy Committee:

1. ***Overview of Health Care Programs in California***:

- Mr. Fox noted the Commission has had a series of panel presentations on ACA health plans or implementation, but has been provided little foundation. The Executive Committee felt such a foundation would be helpful.
- He and Mr. Lester developed seven case studies to explore how the system serves people and create a dialogue. Each case study was followed by multiple-choice questions. Attendees answered with clickers before discussion.
- Joe is 20, lives in Los Angeles County, has an annual income of $16,000, has been HIV+ two years, came to the US from Mexico 10 years ago and is undocumented. Regarding eligibility, only Ryan White or a Federally Qualified Health Center (FQHC) could cover Joe. There are a few exceptions, e.g., those with political asylum or a work permit, but Ryan White is usually the sole program for undocumented PLWH. Covered California could not cover him even if he paid as it requires a Social Security Number, but an employer could fully cover private insurance.
- Ryan White eligibility requires diagnosis with HIV, annual income less than $50,000 and that services are not covered by another payer source. Outpatient core medical and supportive services related to HIV are covered. Inpatient care is not covered under Ryan White. Federal funding is also discretionary so may vary.
- Sandra is 28; lives in Long Beach; has a four-year-old, HIV- daughter; was diagnosed with HIV in 2008 and AIDS in 2009; receives disability benefits; and is eligible for traditional Medi-Cal. Sandra could receive mental health services through Medi-Cal, but services may be capped at eight visits. If she needs more, Ryan White could fill that gap. Adult oral health care was cut from Medi-Cal in 2009. Some services will be restored in May and Ryan White can complete otherwise capped services. Ryan White could also provide nutrition support not offered by Medi-Cal.
- Traditional Medi-Cal eligibility requires an income and asset test; US citizen, national or legal residency for over five years; or disability and emergency Medi-Cal for pregnant women. Sandra would not qualify if she were not HIV+. The ten essential health benefits mandated by ACA are covered. Reimbursement structure may be FFS which pays for any physician who takes Medi-Cal or managed care via Health Net or LA Care in the County.
- There are very few people remaining on Medi-Cal FFS. Primarily they are consumers who had significant continuity of care issues during the transition of Seniors and People With Disabilities to managed care. They have complex medical conditions and received approval from the State to remain on FFS.
- Ben is 27, lives in West Covina, has an annual income of $13,000, identifies as bisexual, is not HIV+ and is in good health, accesses STI testing and treatment services via his local LGBT center, and is eligible for Medi-Cal Expansion. Ben would like to start PrEP and Medi-Cal will cover it without a co-payment. The formulary includes Truvada, approved by the FDA for the prevention of HIV. The CDC covers PrEP administration costs, but not medications.
- Mr. Pérez clarified that PrEP must still be actively prescribed by the Medi-Cal physician. Not all physicians will do so. Beyond Medi-Cal, there are five PrEP studies in the County that enroll consumers. DHSP is considering how to maintain continuity of PrEP for enrollees whose enrollment will expire, in some cases, as early as May 2014. Some PrEP coverage is also available via private insurance. Some such coverage has been smooth, but not all.
- He added PEP and PrEP are both biomendical interventions, but are available via different resources. DHSP funds a PEP program at two sites with Public Health resources.

- Medi-Cal Expansion eligibility requires income less than 138% of Federal Poverty Level (FPL); and US citizen, national or legal residency for over five years. Essential health benefits are covered. Reimbursement structure is managed care via Health Net or LA Care in the County.
- Kim is 41, lives in Torrance, has an annual income of $50,000 as an independent contractor, is a trans woman, and is not living with HIV. She had individual coverage, but her plan was dropped at the end of 2013. She has enrolled in a Covered California plan. Her income is 428% of FPL which places her just above eligibility for Federal subsidies.
- California passed a law and the Department of Insurance issued regulations that any insurance policy for health care coverage must offer trans health coverage, e.g., surgery and hormones. Previously, trans services were often excluded. Service accessibility may vary depending on where an insured person lives in the State.
- Covered California eligibility requires US citizen, national or lawfully present and not incarcerated unless pending trial. Subsidies are available for those with incomes from 138% to 400% FPL or 0 to 400% FPL for legal residents present less than five years who are excluded from Medi-Cal.
- Minimum essential health benefits are covered plus other services a plan chooses to cover. Not eligible for minimum essential coverage through another source, e.g., Medicaid, Medicare or employer. Reimbursement structures vary since coverage is through private health insurance plans.
- Charles is 35, lives in Hawthorne, has an annual income of $30,000 (257% FPL), was diagnosed with HIV three years ago and has been enrolled in Ryan White and ADAP since. His employer does not offer health insurance. He is eligible for Covered California with subsidies, ADAP and OA-HIPP for out-of-pocket costs for medications on the ADAP formulary and the monthly premium. OA-HIPP does not cover deductibles or physician visit co-payments, but advocates hope to expand coverage in future. PLWH can remain on Ryan White and ADAP if they choose.
- OA-HIPP eligibility requires enrollment in ADAP, income less than $50,000, not enrolled in Medicare or Full-Scope (free) Medi-Cal and have or plan to get a comprehensive health insurance plan with prescription drug benefits.
- Dave is 52, lives in Pasadena, has an annual income of $45,000, was diagnosed with HIV 12 years ago, and is enrolled in Anthem Blue Cross through his employer and Ryan White. He may be eligible for several Ryan White services not covered by Anthem Blue Cross, e.g., medical care coordination or adult dental; support services not covered by another payer source, e.g., treatment adherence or transportation; or needed services are capped, e.g., substance abuse treatment. ADAP can also cover co-payments for medications on the ADAP formulary.
- Mr. Land felt the documentation process could be a burden and barrier for a consumer seeking Ryan White services when, e.g., a plan's services are capped. He suggested advocacy to simplify the process.
- Agnes is 67, lives in Los Angeles, is retired, was diagnosed with HIV in 1992 and is living with AIDS. She is currently enrolled in Medicare and Medi-Cal. She wants to continue those services and can do so. She will pay less out-of-pocket for prescription medications as a result of ACA. She could also continue to access Ryan White/ADAP, e.g., to pay for medications when the Medicare donut hole kicks in and out-of-pocket costs increase. ACA reduces the donut hole until it is eliminated in 2020. Ryan White/ADAP became a True Out-Of Pocket eligible payer in 2011.

2. ***2014 Policy Agenda***: This item was postponed.
MOTION 7: Approve the 2014 Policy agenda in accordance with suggested amendments from the 2/13/2014 Commission meeting ***(Postponed)***.

C. Operations Committee: This item was postponed.

1. ***Pol. #09.1007: Community Member Appointments:*** This item was postponed.
MOTION 8: Approve Policy/Procedure #09.1007 (Community Member Nominations and Appointments to Standing Committees), as revised and finalized after public comment period ***(Passed as Part of the Consent Calendar)***.

2. ***Pol. #08.3303: Reimbursable Expenses***: This item was postponed.

3. ***Pol. #08.3105: Federal Conflict of Interest***: This item was postponed.

4. ***Pol #08.3108: State Conflict of Interest***: This item was postponed.

D. Standards and Best Practices (SBP) Committee: This item was postponed.

1. ***Population-Specific Guidelines Format***: This item was postponed.
MOTION 9: Approve the proposed framework/format for Population Specific Guidelines to replace the format for Special Population Guidelines and Population-Based Recommendations/Guidelines, as presented ***(Postponed)***.

15. HOPWA REPORT: This item was postponed.

16. CAUCUS REPORTS: The Consumer Caucus met following the Commission meeting..

17. **TASK FORCE REPORTS**: This item was postponed.

18. CITY/HEALTH DISTRICT REPORTS: This item was postponed.

19. **SPA/DISTRICT REPORTS**: This item was postponed.

20. AIDS EDUCATION/TRAINING CENTERS (AETC): This item was postponed.

21. **COMMISSION COMMENT:**

- Ms. Scholar reported the City of Los Angeles sent an email during this meeting that no AIDS Coordinator's Office contracts will be extended past 3/31/2014. No funding will be available for three months. She was unsure what could be done at this point, but cuts will have a major impact on multiple essential programs including syringe exchange.
- Mr. Zaldivar said budget meetings are being held in various City Council Districts. The community can advocate.
- Mr. Rosales clarified that the City AIDS Coordinator's Office is being removed from the Federal funds part of the budget which runs from April 1st through March 31st. It will be added to the City budget cycle, July 1st through June 30th. He has advised the Mayor's Office that this creates a three-month gap. They had not considered that consequence and had no solution. Multiple programs are affected. He waited until today to inform contractors in hopes that he would know more.
- The Budget and Finance Committee will meet 3/17/2014, at City Hall, Room 340 (Council Chambers), at 6:00 pm. Public comment will be heard. Meeting in the Council Chambers may indicate an expectation of high public participation.
- Mr. Ballesteros felt the Commission legally needed to send communications through the Board of Supervisors. Mr. Vincent-Jones said the Commission can send communications directly, but they do not carry the same weight. The Commission has done so in the past, however, and it is recognized as representing PLWH in the County which carries its own weight.
- Mr. Zaldivar opposed Motion 9A as it only asks for a communication. He proposed an action-oriented motion.
- Mr. Sanjurjo said the City budget comes out April 20th so now is the time to work with people.
- Mr. Land felt the motion should be a recommendation to the Board of Supervisors since Commission members serve at their pleasure. Ms. Forrest disagreed. The matter should be approached as seriously as if there were to be a three month gap in services for HIV care. As a Commission, if we are equally invested in prevention as we are in care, then it should be treated exactly the same way. Anything less is a statement on the Commission's part that it does not care about prevention.
- Mr. Ballesteros liked the idea of being able to send a letter directly to the Mayor, but felt the best strategy was to send a letter to the Board of Supervisors to enlist the Board in advocacy with the Mayor's Office. He felt it counterproductive to send a letter without the concurrence of the Board. He would oppose a motion without a letter directed to the Board.
- Ms. Scholar said funding ends in 17 days and would, e.g., shut down all syringe exchange services in Hollywood and Pico Union. Addressing the Board of Supervisors would take too long.
- Mr. Land suggested two letters: one to the City expressing concern and one requesting support from the Board.
- Mr. Johnson noted he is moving into the District 4 seat. He concurred with Mr. Ballesteros that our mechanism is to communicate to the Board. Mr. Vincent-Jones has assured him a letter can go out within the next 24- to 48-hours. It is important that the Board Offices are aware of the Commission's concern. It is our responsibility as a County Commission to advise them of concerns as quickly as possible. Board Offices also have their own contacts with City offices.
- Mr. Vincent-Jones said how to address the issue strategically is the Commission's choice, but things can be worded differently to different recipients to get the point across without crossing the line of protocol within the County. This is the Los Angeles County Commission on HIV, but the Commission is also responsible for the Comprehensive HIV Plan which is developed with our administrative partner. There is therefore room to address issues such as gaps in funding and how the service delivery mechanism as a whole is addressed. He felt some Board Offices expected the Commission to do that.
- Mr. Rosales said he has been speaking with both the Mayor's and Council Members' Offices. A letter is useful Showing up is more useful. They pay a lot of attention when people go and talk with them face to face. The AIDS Coordinator's Office is not the only program affected. He has been there every other day so they do not forget about the Office.
- The administrative budget has not been affected. The cut is to funds for programming. The AIDS Coordinator's Office is the sole source of funding for some services, especially syringe exchange, in the City of Los Angeles.

➲ Mr. Zaldivar agreed to amend Motion 9B to include letters to both the Board of Supervisors and the City of Los Angeles.

MOTION 9A: ***(Ballesteros/Rosales)*** Send a letter from the Commission to the Board of Supervisors and the City of Los Angeles regarding this action seeking clarification and impact on the programs ***(Withdrawn)***.

MOTION 9B: ***(Zaldivar/Land)*** Send a letter from the Commission to the Board of Supervisors expressing concern and a letter to Mayor Eric Garcetti and City Council Offices expressing concern and requesting they fill any gaps in funding between now and the end of the City's budget year and to prioritize funding for the City AIDS Coordinator's Office to continue the services that they provide to our community ***(Passed: 20 Ayes; 2 Opposed; 1 Abstentions)***.

22. ANNOUNCEMENTS: There were no additional announcements.

23. ADJOURNMENT: The meeting adjourned at 2:30 pm.

A. Roll Call (**Present)**: Ballesteros, Granados, Green/Sanjurjo, Johnson/Donnelly, Kelly, Kochems, Kushner, Land, Liso, Lester, Lopez, McMillin, Munoz, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Scholar, Smith, Winder, Zaldivar

MOTION AND VOTING SUMMARY		
MOTION 1: Adjust, as necessary, and approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the Commission on HIV meeting(s), revised as appropriate, as presented.	***Withdrawn***	**MOTION WITHDRAWN**
MOTION 3: Approve the Consent Calendar, with agenda motions removed as necessary.	***Passed by Consensus***	**MOTION PASSED**
MOTION 4: Approve final, year-end revisions to FY 2013 allocations, as presented.	***Ayes:*** Ballesteros, Cadden, Cataldo, Ceja, Enfield, Fox, Granados, Green, Johnson, Kelly, Kochems, Kushner, Land, Lester, Liso, Lopez, McMillin, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca, Scholar, Smith, Tula, Zaldivar ***Opposed:*** None ***Abstentions:*** Kiburi, Winder	**MOTION PASSED** **Ayes**: 27 **Opposed**: 0 **Abstentions**: 2
MOTION 5: Modify the FY 2014 Ryan White Parts A/B and Minority AIDS Initiative (MAI) allocations, as necessary and recommended.	***Ayes:*** Ballesteros, Cadden, Cataldo, Enfield, Granados, Green, Johnson, Kelly, Kochems, Kushner, Land, Lester, Liso, Lopez, McMillin, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca, Smith, Tula ***Opposed:*** Fox, Winder ***Abstentions:*** Kiburi, Scholar, Zaldivar	**MOTION PASSED** **Ayes**: 23 **Opposed**: 2 **Abstentions**: 3
MOTION 6: Approve recommended FY 2014 Directives to administrative partners, revised if necessary and as appropriate.	***Ayes:*** Ballesteros, Green, Johnson, Kelly, Kochems, Kushner, Land, Lester, Liso, Lopez, McMillin, Pérez, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca, Smith, Winder, Zaldivar ***Opposed:*** None ***Abstentions:*** Fox, Kiburi, Scholar	**MOTION PASSED** **Ayes**: 20 **Opposed**: 0 **Abstentions**: 3
MOTION 7: Approve the 2014 Policy agenda in accordance with suggested amendments from the 2/13/2014 Commission meeting.	***Postponed***	**MOTION POSTPONED**
MOTION 8: Approve Policy/Procedure #09.1007 (Community Member Nominations and Appointments to Standing Committees), as revised and finalized after public comment period.	***Postponed***	**MOTION POSTPONED**

MOTION AND VOTING SUMMARY		
MOTION 9: Approve the proposed framework/format for Population Specific Guidelines to replace the format for Special Population Guidelines and Population-Based Recommendations/Guidelines, as presented.	***Postponed***	**MOTION POSTPONED**
MOTION 9A: ***(Ballesteros/Rosales)*** Send a letter from the Commission to the Board of Supervisors and the City of Los Angeles regarding this action seeking clarification and impact on the programs.	***Withdrawn***	**MOTION WITHDRAWN**
MOTION 9B: ***(Zaldivar/Land)*** Send a letter from the Commission to the Board of Supervisors expressing concern and a letter to Mayor Eric Garcetti and City Council Offices expressing concern and requesting they fill any gaps in funding between now and the end of the City's budget year and to prioritize funding for the City AIDS Coordinator's Office to continue the services that they provide to our community	***Ayes:*** Granados, Green, Kelly, Kochems, Kushner, Land, Lester, Liso, Lopez, McMillin, Munoz, Rios, Rivera, Rosales, Rotenberg, Samone-Loreca, Scholar, Smith, Winder, Zaldivar ***Opposed:*** Ballesteros, Johnson, ***Abstentions:*** Pérez	**MOTION PASSED** **Ayes**: 20 **Opposed**: 2 **Abstentions**: 1